

DECEMBER 1991

ACADEMIC MEDICINE

JOURNAL OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES



Implications of Ending Mandatory Retirement

Litigation Involving Residents: Part II

Medical Students' Professional Ethics

A Humanities and Medicine Program for Faculty

The Contribution of Medical Missions

Undergraduate Ambulatory Care Education

Stability of Specialty Selection at U. Ky.

Validity and Accuracy of Self-assessments

Factors Affecting Residents' Parenting Decisions

Evaluation of Clinical Teaching at U. Va.

Primary Care Preceptorship for the Underserved

Retraining Faculty for Problem-based Learning

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SPECIAL ARTICLES

ROBERT F. JONES, Ph.D.

The End of Mandatory Retirement and Its Implications for Academic Medicine

Abstract—The prohibition against age-based mandatory retirement, codified in amendments to the Age Discrimination in Employment Act (ADEA) in 1986, remains a concern in the academic medical community. A seven-year exemption covering tenured faculty expires at the end of 1993. The author reviews the legislative history of the ADEA and explores in detail the planning and management issues—and the available projections of likely faculty behavior in the future—concerning the banning of age-based mandatory retirement of higher education faculty, with special reference to the academic medical community. Although the major studies concerning the probable course of

events after the seven-year exemption expires indicate that there will not be a cataclysmic effect on institutions of higher education, it is still not certain how tenured faculty will behave and how that will affect medical schools. The author cautions that the management acumen of institutional leaders will be taxed, and that medical school deans should realize this and begin the transition into the new era by improving systems for faculty evaluation and development, clarifying the financial guarantees of tenure, implementing space utilization reviews, and developing programs to make retirement attractive. *Acad. Med.* 66(1991):711-718.

The prohibition against age-based mandatory retirement, codified in amendments to the Age Discrimination in Employment Act (ADEA) in 1986,¹ remains a concern in the academic medical community, particularly among institutional leaders. Softening the immediate impact of the legislation was a seven-year exemption covering tenured faculty, which is set to expire December 31, 1993. In an effort to determine whether such an exemption should be made permanent, Congress commissioned the National Academy of Sciences (NAS) to conduct a study of the impact on higher education of "uncapping" the retirement age. The NAS Committee on Mandatory Retirement in Higher Education (hereinafter the NAS Committee), which was charged with that study, has now released its report and concluded that the exemption for tenured faculty should be allowed to expire.²

The NAS Committee conducted a thorough examination of the issue and its conclusions are well documented. Yet, they should not be interpreted to mean that ending mandatory retirement will be inconsequential for institutions. The implications of ending mandatory retirement for *planning* must be distinguished from those for *management*. The NAS Committee focused largely on the former issues. Data available to the NAS Committee (and reviewed here) suggest that fears of the delayed retirement of faculty members are largely overstated; indeed, a greater challenge for planning may be how to replenish faculties depleted by large numbers of retirements. However, the management problems institutions experience as a result of ending mandatory retirement may be profound, and in many respects will change the way in which schools conduct their business. It is these problems that constitute the main focus of this paper. Prior to addressing them, however, the legislative history and planning issues that have engaged the political debate are described.

Legislative History

Although passage of the ADEA amendments in 1986 came as a sur-

prise to many in the academic medical community, it was in fact the culmination of a longstanding political and legislative debate on the civil rights of the elderly. The debate can be traced back at least to the 1961 White House Conference on Aging.³ It was not until 1967, the year of the original ADEA, that safeguards protecting those between the ages of 40 and 65 from discrimination in employment on the basis of age were enacted into law. While the ADEA was a major advance for those fighting against age discrimination, it was also a setback, since it codified the then-prevalent practice of having workers retire involuntarily at age 65.

The considerable political influence wielded by the American Association of Retired Persons (AARP) and the personal championship of the late Representative Claude Pepper led to the passage in 1978 of amendments to ADEA that raised the mandatory retirement age from 65 to 70.⁴ The higher education community in Washington lobbied hard against the 1978 amendments. While unsuccessful, it did obtain a specific, three-year exemption for tenured faculty. That exemption expired without fanfare in 1982. Many institutions had changed their policies immediately to a mandatory retirement age of 70.⁵

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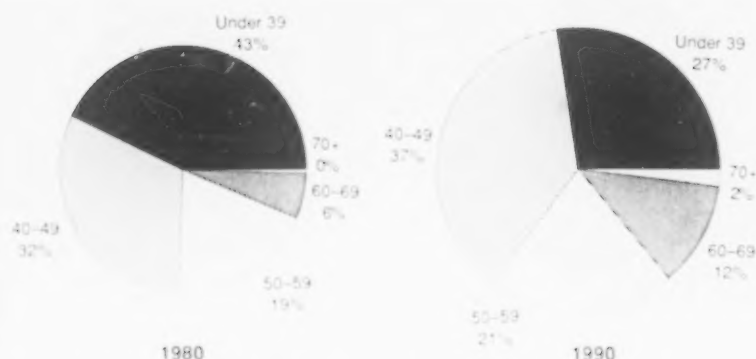


Figure 1. Ages of U.S. medical school faculty members. (Source: AAMC Faculty Roster.)

Stauffer⁶ reports that discussion on prohibiting mandatory retirement at any age began almost immediately after passage of the 1978 amendments, but it took until 1986 to see that goal codified into law. When passage of the 1986 amendments appeared certain, the higher education community, led by the American Council on Education (ACE), pressed for a 15-year exemption. ACE argued that this period would enable institutions to retire the cohort of faculty hired during the expansion era of the 1960s. The seven-year exemption was a political compromise offered to the higher education community on a "take-it-or-leave-it" basis.³

Since 1986, organized opposition to uncapping has nearly dissipated. The American Association of University Professors (AAUP), which to the surprise of some had supported mandatory retirement, reversed its position and announced that it would no longer oppose the ending of the tenured faculty exemption.⁷ The AAUP was initially concerned that eliminating mandatory retirement would seriously limit advancement opportunities for junior faculty and threaten the concept of tenure in higher education. It has now decided that these concerns are largely unfounded.^{8,9}

The ground swell in Congress in support of ending mandatory retirement—passage of the 1986 amendments to ADEA in the House of Representatives was unanimous—

has been mirrored in state legislatures. Before 1986, only six states had statutes that prohibited mandatory retirement for all, including tenured faculty: Florida, Maine, Montana, Utah, Wisconsin, and Nevada (at least eight more, including New York and California, prohibited mandatory retirement, but tenured faculty were exempted). Since 1986, Hawaii, Virginia, and Texas have passed laws forbidding mandatory retirement, including that of tenured faculty.

Planning Issues

The primary argument in support of mandatory retirement is based on the assumption that faculty members will delay retirement beyond age 70 when permitted to do so, or at least that a significant number will, and that these may well be among the least productive members of the academic community. If true, three consequences would ensue:

1. fewer positions would be available for new hires, particularly for women and minorities, who are now underrepresented, thus limiting faculty renewal (the so-called "lost generation of scholars" argument);
2. the faculty as a whole would be older, and this would have consequent negative implications for productivity; and
3. an older faculty with corre-

spondingly high salaries would create severe economic hardship for institutions.

A comparison of the age distributions of medical school faculty now and a decade earlier highlights the significance of these issues. In 1980, only one-fourth of the faculty were 50 years old or older; today that group constitutes more than one-third of faculty members (Figure 1). Whether the current cohort of age 50+ faculty, hired during the period of expansion in the 1960s and early 1970s, chooses to retire at the normal age or opts for extended service clearly has important implications for medical schools.

Will Faculty Delay Retirement?

If medical school faculty follow national labor trends, there would be little reason to predict their delayed retirement after 1993. The national labor force, spurred by improved pension income arrangements, has shown a penchant for early retirement.^{10,11} Studies by the Teachers Insurance Annuity Association—College Retirement Equities Fund (TIAA—CREF) provide a more focused appraisal of faculty retirement patterns, although not an unequivocal one, since participants in TIAA—CREF plans include staff as well as faculty at member institutions. The ages at which participants in these plans have elected to start receiving annuity income have become more varied over the past decade, but with little change on average.¹²

Faculty responses to the 1978 Amendments to the ADEA, which raised the mandatory retirement age from 65 to 70, provide perhaps the best glimpse of the behavior that is likely when the age is uncapped altogether. The law allowed institutions a three-year (until 1982) exemption for tenured faculty. One study,¹³ based on data from 12 public institutions that are members of the Association of American Universities (AAU), found no change in the average age of retirement between 1982 and 1986. Data collected by the Consortium on Financing Higher Education

(COFHE)¹⁴ showed no change in the retirement ages at eight other public universities during the same time period. Friedman¹⁵ has now confirmed that the average ages of retirement (defined as final separation from full-time academic employment after age 60) that occurred among medical school faculty during this period fluctuated in the narrow range of 66.1 to 66.7 years.

Data from the COFHE study revealed a retirement trend for the 16 private research universities and seven private liberal arts colleges in the sample that was different from that observed at the public universities. At the former group of schools the average age at retirement increased from 64.7 to 66.3 years between 1982 and 1986. In another study¹⁶ it was determined that faculty at private institutions anticipated a later retirement age (by two years) than did faculty at public institutions. While these differences in retirement patterns are modest, they do explain why concerns about the deleterious consequences of uncapping appear to be expressed most vociferously by private, often research-intensive, institutions.¹⁷ These institutions have been more reluctant to abandon mandatory retirement voluntarily and have more frequently used exemptions granted to colleges and universities.¹⁸

The differences in retirement patterns among types of institutions are mirrored in studies of faculty attitudes. In a major survey conducted by the Carnegie Foundation,¹⁸ only 37% of faculty from research universities expressed an interest in an early retirement option, the lowest percentage among the faculties from the five types of institutions studied. Faculty at research universities were also least likely to acknowledge that they looked forward to retirement as an enjoyable period of life. One factor posited to explain why faculty at research universities are less anxious to retire is that their teaching loads, which for faculty at most institutions may serve as an incentive to retirement, are lighter. The prospect that faculty at private, research-intensive

universities may be more likely to delay retirement under the new law has been acknowledged by the AAUP.⁸ Moreover, the NAS Committee singled out research-intensive institutions as the one category of institutions likely to witness high numbers of faculty delaying retirement past age 70 when permitted to do so.²

The premise that delayed retirement will be selective and include disproportionately faculty who contribute little to the academic enterprise deserves serious consideration. Protected by tenure, these few faculty members in a period of limited resources may be enough to constrain new initiatives in teaching and research and consign departments to enduring mediocrity. However, there is little support for the nightmarish implications of this premise. Studies by TIAA-CREF¹⁹ indicate that the four factors retirees posit as the most important in that decision are (in order of importance): (1) the degree of assurance of a satisfactory retirement income; (2) the state of one's health; (3) the degree of satisfaction or dissatisfaction with one's job; and (4) the extent to which one is able to perform the job up to expectations. These last two reasons suggest that faculty whose productivity is diminished may be least motivated to continue.

Studies of faculty who retire tend to support this thesis. Faculty who publish frequently and have earned numerous awards tend to retire later.²⁰ Those who exhibit or report a decline in research activity^{16,21} or indicate a lessened enthusiasm for teaching²² are likely to retire earlier. Institutions may have to deal with individual cases that are counter to this trend, but they are likely to be the exception. As such, they constitute a management rather than a planning problem.

In conclusion, the change in law raising the mandatory retirement age from 65 to 70 at most had a small effect on the age at which faculty chose to retire. There is no reason to expect that uncapping would have a more dramatic impact. Some schools

may experience no change in retirement patterns. Private, research-intensive institutions may be the one exception to this general trend.

Fewer Positions for New Hires?

The effect that uncapping might have on reducing the number of faculty positions available for new hires—to stimulate faculty renewal in general and to remedy the underrepresentation of women and minorities in particular—is an argument raised by supporters of mandatory retirement that receives instant recognition and sympathy. However, a simple analysis shows that massive change in the retirement patterns of faculty would be needed to have any long-term impact on the ability of institutions to renew their faculties. For example, if faculty tended to delay retirement for a few years on average, thus shifting the distribution of retirement ages, institutions would experience in those first few years a decrease in the expected retirement rate and, all other things being equal, fewer openings. But the major impact would be short-term. After the delays in retirements are accommodated, that is, retirement ages stabilize in a new distribution, openings via retirement should occur at nearly the same rate as before.

Friedman²³ has demonstrated this in his modeling of the retirement and renewal process among health sciences faculty in the University of California system. The impact of a projected delayed retirement was found to be relatively inconsequential. Critical to the ability of institutions to renew faculties were assumptions about the faculty growth rate. Friedman¹⁶ has now repeated his study using data from the national roster of medical school faculty maintained by the AAMC. His conclusion is unchanged.

Despite predictions that medical school faculties will not grow significantly over the next decade, certainly not at the rate that produced a sixfold increase since 1960, the problem confronting medical schools may not be the lack of openings but a lack of peo-

ple to fill them. While initial concerns in the higher education community about eliminating mandatory retirement focused on the prediction that most of the faculty members hired in the 1960s would not retire, a more recent anxiety is the problem in reverse: what happens when they do retire. Some recent studies have predicted a severe shortage of faculty in other academic and professional fields, including humanities and social sciences,²⁴ as well as in languages, mathematics, life sciences, physical sciences, engineering, and science and engineering technology.¹³ These projections are based on the large percentages of older faculty in these fields. Losier and Dooris¹³ indicate that the rate of faculty retirements will increase 150% during the late 1990s. In another study, Connellan²⁵ has projected the retirement rate to double through the year 2010.

None of these studies is based specifically on medical school faculty, but a review of Figure 1 indicates that similar scenarios for academic medicine can be imagined. In fact, concern about this issue has already been raised, mainly in the context of renewing the pool of trained biomedical researchers.²⁶

A Less Productive Faculty?

Medical school faculties are older; delayed retirement would make them older still. The degree to which advanced age translates into diminished effectiveness has been the focus of studies that have yielded mixed results.

For example, the hypothesis that with advancing age teaching effectiveness, at least as measured by students' ratings, is diminished is generally not supported.^{27,28} Studies have shown that the relationship between age and research productivity varies by discipline.²⁹ In fields where there are documented declines in performance, the relationship is typically quite weak. For example, one study of biochemistry faculty³⁰ revealed a deleterious effect of aging on productivity, as measured by published research articles, but age alone

accounted for less than 2% of the variance.

Sherman and colleagues,³¹ also using publications as a measure of performance, found relationships between career age and research productivity among medical school faculty that differed by discipline. Publishing trends of faculty with M.D. degrees in surgery specialties, hospital-based specialties, and basic sciences each could be portrayed by an inverted-U-shaped curve, documenting a midcareer peak period of productivity followed by a steady decline. However, those in medical specialties and behavioral specialties tended to reach and maintain a plateau in publishing in both refereed and non-refereed journals.

The clinical performance of faculty with M.D. degrees, and how it might decline with age, is a further consideration. Here, a more pressing value than publication may be at stake: patient safety, particularly in specialties that depend upon manual and psychomotor skills. Those who press this argument, however, misunderstand that supporters of uncapping do not deny the eventual diminution of skills and intellectual contributions over time. They simply argue that there are a number of factors that moderate the relationship between age and performance, and that age itself is a poor proxy for direct observation and assessment. Current trends to institute relicensure and recertification requirements are consistent with this theme.

Higher Faculty Costs?

The increase in institutional costs that would accompany delays in faculty retirement is evident. Faculty salaries are directly correlated with age. Also, unlike the impact of delayed retirement on openings for new faculty hires, this effect would be permanent. Delayed retirements would force a shift in the age distributions of faculties, eventually stabilizing but at a higher median point. Actually, increases in faculty salary costs have presumably been occurring as a result of the aging of the faculty over the

last decade, although the specific effect of faculty aging on faculty costs has not been estimated.

Simulation studies of the financial impact for colleges and universities of raising the mandatory retirement age from 65 to 70, under worst-case scenarios, have resulted in estimated cost increases of 3% or less.^{16,20} The financial impact for medical schools could be more or less than this percentage. Complicating such an analysis is the degree to which medical school faculty derive their own salary support through research grants or clinical practice. Continuing salaries for certain faculty can indeed be burdensome, for example, former chairs, who may no longer have grants to support the salary or the space they maintain. Yet, other cases are evident in which the retirement of a faculty member would be financially disadvantageous to the institution. In research particularly, the eminence of certain older faculty can be a boon in securing research funding.³²

While a 3% increase in costs is generally regarded as insignificant for a school of arts and sciences, it may be less so for a medical school. In a \$10-million-dollar department of medicine budget, a 3% increase would rob dollars that could be used to support between three and five faculty, assuming that they earn half their annual compensation through grants or clinical practice. A high financial price to be paid by institutions for ending mandatory retirement may not be inevitable, however, particularly if certain management initiatives, proposed in the next section, are pursued.

Management Issues

The management challenges presented by the end of mandatory retirement tend to fall in four areas. First, medical schools will face increasing pressure to implement more active systems for faculty evaluation and development. Second, they will need to define more clearly the guarantees of tenure, in particular, financial support guarantees. Third, they will be required to initiate changes in

institutional culture regarding the "ownership" of space, particularly scarce laboratory space. Fourth, they will be encouraged to develop, in concert with their parent universities, a several-pronged program to make retirement more attractive, particularly for selected members of the faculty.

Faculty Evaluation and Development

When mandatory retirement ends, institutions will no longer have a painless method for discharging faculty who are incompetent or who have otherwise become "disengaged." In actuality, mandatory retirement has been only marginally effective in helping institutions deal with these problems. Uncapping may cause institutions to deal with these issues more directly.

The case of the truly incompetent faculty member, one who has become an anathema to peers and colleagues, is admittedly an infrequent problem. However, protected by tenure, such persons have been viewed as immune from normal review processes and impervious to suspension and removal. Even the AAUP is quick to assert that such protections are a distortion of the concept of tenure and, as such, weaken it. Despite this, institutions have been reluctant to confront the issue directly, no doubt fearing the financial and energy-dissipating consequences of protracted court battles. Although the courts tend to respect and support academic decision making when institutions follow their own pre-established procedures,³³ medical schools may anticipate success in litigation as only a Pyrrhic victory. The University of California at Berkeley has developed a proposal³⁴ in which "gross incompetence" is defined and procedures for dismissing professors who meet the definition are outlined. While the proposal has not yet met with acceptance, it is one of several signs that the uncapping of mandatory retirement is strengthening the resolve of institutions to confront the issue of incompetent faculty more directly.^{35,36}

A more frequent problem is that of the "disengaged" faculty member.

Such individuals may be only marginally productive for various reasons. Their fields of expertise may have declined in importance, or their personal capacities may have diminished, or simply the promise they showed upon the award of tenure may not have been fulfilled. Disengaged faculty can be identified typically in their mid-fifties; therefore, mandatory retirement at age 70 has always been limited as a mechanism to deal with such cases.³⁷

Proposed changes to deal with this problem inevitably include instituting some form of post-tenure performance evaluation, a practice viewed with suspicion by some faculty as a subterfuge for undermining tenure and due process. It need not be. Post-tenure review that is faculty-designed, formative in purpose, and tied to a visible faculty development program to which the institution has put resources is the logical response to this issue.^{38,39} As one example, a system-wide University of California committee dealing with the health sciences has proposed creation of a "faculty development committee" to which tenured faculty members who fail to receive normal merit advancement would be directed.³⁷ The committee would be charged with monitoring the progress of the faculty member as he or she pursued the terms of a negotiated "constructive contract." The University of Hawaii has already had success in instituting a similar plan.⁴⁰ Early intervention and an institutional culture that stresses development appear to be key to forestalling problems of faculty disengagement.

These initiatives, if they become more widespread, guarantee an evolution in the concept of tenure. As the right to serve until the age of retirement, tenure inevitably must be redefined now that retirement age is no longer fixed. A corollary to this is a shift away from the academic culture and toward a more management-oriented culture at many institutions. It parallels shifts in culture that medical school faculty have already experienced in the delivery of health services: a new-found preoccupation

with efficiency, outcomes, and accountability. It is a shift long feared by those who oppose the elimination of mandatory retirement, and it is not without risk. Of paramount importance will be the development of evaluation procedures that are deemed to be fair and gain the support of tenured faculty. Equally important will be managerial acumen and sensitivity in the implementation of these procedures.

Guarantees of Tenure

The practice of granting tenure has been adopted widely in academic medicine. Only six of the nation's 126 accredited medical schools do not recognize tenure, while another seven observe it only in the case of basic science faculty. Despite its near ubiquity, the meaning attached to tenure among institutions is far from uniform and unambiguous. In a 1983 survey,⁴¹ respondents from 101 medical schools indicated the following as "guaranteed" by tenure at their institutions: "total salary" (13%); "teaching salary" (11%); "percentage of some stated salary figure" (7%); "continued appointment at a designated faculty rank without salary guarantee" (47%); "other" (33%). Many of the respondents who opted for the last category stated frankly that the guarantees of tenure awarded at their institutions were unclear.

The variety of sources of funds from which medical school faculty salaries are paid and the degrees to which medical school revenues are generated by the faculty themselves, through research and clinical service, further complicate the picture for academic medicine. As a result, it is not uncommon for tenured faculty to be paid salaries from essentially "soft" sources, such as research grants. A drying-up of such grants can cause immediate and severe problems for the institution in such cases. In addition, administrative responsibilities, such as those assumed by a department chair, may result in a special salary adjustment, but the link between those responsibilities and the salary differential is not always made clear.

Clearer communications with faculty about the sources of their support, the guarantees attached to those sources, and the special protections afforded them in the award of tenure must replace the vague understandings that exist in many places today. Medical schools obviously cannot provide open-ended guarantees to those whose research funding or clinical service affords them remuneration that far exceeds that of their colleagues on the main campus. Already, there appears to be some recognition of this fact.⁴²

Space Management

The most precious institutional resource tied up by faculty who delay retirement may not be high salary costs, but space. Space is often viewed as the limiting factor in the expansion of biomedical research programs. In an era in which direct federal funding for construction of facilities has been virtually nonexistent, increasing the amount of research space has been difficult, intensifying the need for an active program of monitoring space utilization and productivity.

Several schools have active programs in this area.⁴³ The methods include formula-based approaches that link assigned square feet to revenues generated by the space, those that are based on predetermined institutional priorities for space assignment, and those that rely on traditional faculty peer review procedures for evaluating space utilization and making recommendations for change. Each of these schools has been able to gain faculty acceptance for space reallocation based on predefined methods and criteria.

At many other schools, the political culture creates obstacles to active space management and utilization review. Faculty members' space is sometimes viewed, like their titles, as protected by tenure, although no rational basis for the practice exists. Changing this culture requires the awareness and support of faculty, similar to that for improving systems for faculty performance evaluation. Both changes are in a sense a price

for the other protections to be afforded to tenured faculty once the current exemption is lifted.

Incentive Retirement Programs

In considering ways to make retirement attractive when it can no longer be mandated, financial incentives are often the first thought. Yet, the attractiveness to faculty of phased retirement programs^{16,22} reflects the value they place on retaining ties to academia. Recognition of this has spurred an interest in formalizing plans for emeriti status.⁴⁴

Policies regarding and provisions for emeriti are usually determined by central university administration. Medical schools need to understand how such policies and provisions deter or encourage medical school faculty retirement. Albert⁴⁵ has chronicled an extensive list of potential rights and privileges for emeriti. Many of these, for example, library privileges, receipt of campus publications, listings in directories, etc., can be accommodated at little or no cost to the institution. Others are at greater cost, including office space, secretarial support, supplies, and mailing privileges. Office space, even shared, may be difficult to accommodate, but is extremely facilitative of retirement, since it provides faculty with a base for continued writing and consulting.

Opportunities for emeriti to participate in research and teaching, albeit in a limited way, appear to be highly desired. Furnishing laboratory space is generally prohibitive, but other creative ways to involve retired faculty in contributing to the institution are needed. As one example, the University of Wisconsin School of Medicine engages retired faculty as mentors to first-year medical students.

Structured programs for emeriti are likely to become more frequent, even a norm, as a result of institutional concern with the end of mandatory retirement. However, institutions may still need to provide financial incentives to spur faculty retirements. According to Chronister and Kepple,⁴⁶ incentive-based early retire-

ment programs are of two varieties: formal plans "with specific guidelines, policies, and procedures under which any faculty member meeting the established criteria for eligibility may apply to participate" and ad hoc plans in which "each early retirement is negotiated separately with the individual faculty member." The latter approach, the buyout, appears to be more common in medical schools. It has the advantage of targeting limited resources to faculty whose retirement is most beneficial to the institution. However, it tends to engender equity concerns and is vulnerable to the perception of rewarding poor performance.

Formal plans are most often university- or state-based and therefore offered to a broad cross section of faculty and nonfaculty employees. As such, they may not provide the right incentives for medical school faculty to participate. To be effective, formal early retirement plans should be thought of as personnel management strategies rather than faculty benefit programs. Plans should be developed with specific objectives in mind and have an eligibility period for enrollment that is time-limited.⁴⁶ The University of California's recent decision to offer early retirement is a prime example.⁴⁷ Faculty whose ages plus years of service total 80 or more qualify to receive credit for five additional years of service in the calculation of their defined-benefit pension plan if they retire by a specific date in 1991. The program is expected to cut costs significantly. As with other formal plans, a potential problem is that the California plan might encourage productive and valuable faculty to retire, to the detriment of institutions. For this reason, the plan has reserved mechanisms for rehiring faculty on a part-time and/or short-term, contractual basis.

In commenting on the issue of incentive retirement programs as a tool to encourage faculty renewal, the NAS Committee concluded that institutions will need the help of Congress, the Internal Revenue Service, and the Equal Employment Opportunity Commission in preserving insti-

tutional flexibility to design programs to meet specified objectives while avoiding discrimination.² The NAS Committee was the first to point out that current requirements to continue institutional contributions to defined-contribution retirement plans constitute a disincentive to retirement that institutions need to overcome. The NAS Committee believed that legally permissible ways to limit such contributions, when they result in retirement pensions greater than 100% of salary, need to be designed. Moreover, the NAS Committee noted the difficulties for institutions that Congress has created by declaring as immediately taxable deferred severance pay and urged that institutions be permitted to design incentive retirement programs targeted to specific groups according to institutional need. While Congress may not look favorably on extending the tenured faculty exemption after 1993, it may be responsive to these other importunings.

Conclusion

The ending of mandatory retirement reflects an emerging social ethic: age, like gender and race, cannot be used as a basis for differential treatment. As the population inexorably grows older, this ethic is likely to be reinforced in the public consciousness. Currently, tenured faculty constitute one of only a few societal groups accorded different treatment under the law. This is not likely to continue.

One cannot predict with any certainty how tenured faculty will behave and how that will affect medical schools once the exemption for tenured faculty is lifted. The NAS Committee has reviewed available studies and determined that there will not be a cataclysmic effect on institutions of higher education. However, the management acumen of institutional leaders will be taxed. Medical school deans and department chairs must anticipate this reality and plan accordingly for a new era in which retirement cannot be mandated. Improving systems for faculty evaluation and development, clarifying the

financial guarantees of tenure, implementing space utilization reviews, and developing programs to make retirement attractive are places to start.

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LELIA B. HELMS, J.D., Ph.D., and CHARLES M. HELMS, M.D., Ph.D.

Forty Years of Litigation Involving Residents and Their Training: II. Malpractice Issues

Abstract—The authors reviewed 136 cases of malpractice litigation involving residents or programs of graduate medical education that were reported from 1950 through 1989. Before 1970 malpractice constituted the only area of reported litigation for residents. The number of malpractice cases involving residents increased substantially after 1975, paralleling the growth of malpractice cases nationally. The regional pattern of reported cases involving residents also corresponded with previous findings.

Questions of vicarious liability, the applicable standard of care, and residents' supervision were at issue in the great majority of cases. Questions related to judicial procedure, immunity from liability, breach or causation, and informed consent were also litigated. Residents were on the side of the prevailing party in 44% of the cases. Malpractice continues to be the key legal issue facing programs of residency training. *Acad. Med.* 66(1991): 718-725.

In a previous paper we identified a substantial body of litigation involving resident physicians and graduate medical education, and reviewed cases concerned with programmatic issues.¹ A much larger group of cases litigating claims of medical malpractice is the focus for this paper. There

is little information available in any systematic form about malpractice claims involving residents and programs of graduate medical education.² In this study we review the reported litigation, classify the primary issue and decision in each case, and evaluate the results in the context of the available literature on malpractice and resident education. Finally, we discuss the educational implications of malpractice claims as they affect residency training programs.

Method

Cases involving residents or programs of graduate medical education were

identified for the period 1950-1989 through the Westlaw computerized legal research services, employing topical indexes and key word descriptors as previously described.¹ While the Westlaw database includes most reported federal and state court decisions, the number of cases reported constitutes but a fraction of the actual number of cases that are actually filed, dismissed, or decided. Moreover, the reporting system is biased toward appellate-level decisions. Despite these limitations, the number of reported decisions provides an indirect indicator of case volume. More important, reported decisions constitute the sole body of law serving as

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precedent to future legal decisions in the area.

Results and Analysis

Reported litigation underwent substantial changes in volume as well as in a broadening of issues litigated over the 40-year study period.

Volume of Litigation

One hundred-thirty six cases of malpractice litigation involving residents or programs of graduate medical education were reported from 1950 through 1989 (Table 1). Litigation increased dramatically during the latter half of the study period. From 1950 through 1974, there was no apparent pattern of growth. From 1975 through 1979, the number of cases reported more than doubled, however, and from 1985 through 1989, the number of reported cases had nearly doubled again.

Malpractice, an issue of negligence, is litigated primarily in state courts that have jurisdiction over common law torts. Consistent with this, 116 (85%) of the cases reported in this study were decided in state courts. The number of malpractice cases varied substantially by state. The regional pattern of occurrence, however, was consistent with previously reported annual incidences of medical malpractice claims indicating highest incidences in the northeastern states and progressively lower incidences in the north central, southern, and western states.³ New York accounted for 24 (18%) of the malpractice cases. Next in order of frequency of reporting were Pennsylvania and Michigan, with 11 and ten cases, respectively. Only four malpractice cases were identified from California. Twelve states reported no malpractice case at all. The large number of cases from New York may reflect, at least in part, an anomaly in the reporting system, since a greater number of trial court decisions are included in that state's reporting system. Further, according to the American Medical Association's M-E-R-I Database, the number of residency positions offered

Table 1
Cases Involving Issues of Medical Malpractice and Graduate Medical Education

	Federal	State	Total
1950-1954	1	4	5
1955-1959	1	8	9
1960-1964	—	8	8
1965-1969	3	7	10
1970-1974	4	5	9
1975-1979	2	21	23
1980-1984	4	26	30
1985-1989	5	37	42
Total	20	116	136

in New York constitutes 15% of the national total, a proportion far exceeding that of any other state.*

Twenty cases were decided in federal courts. Generally, federal courts hear malpractice cases only when federal standards of diversity jurisdiction can be met. In such instances the parties to the litigation are from different states and the amount of damages exceeds minimum standard, although the case is decided under applicable state law. In only a few cases did an issue arise under federal law, such as the Veterans Administration statutes or the Federal Tort Claims Act.

Issues Giving Rise to Litigation

Table 2 categorizes the reported malpractice cases by the primary issue

addressed in the decision by the courts. Malpractice claims litigate the question of negligence, that is, "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm."⁴ In order to establish liability for negligent malpractice, the plaintiff must show that the defendant owed a *duty of care* to the patient and violated the applicable *standard of care*, which resulted in the plaintiff's suffering a compensable *injury*. In addition, the plaintiff must comply with any jurisdictional or procedural prerequisites to litigation.

Duty of care. The question of who owed a duty of care to the plaintiff was litigated consistently over the entire study period and accounted for 40 (29%) of the 136 cases. The period from 1950 through 1989 witnessed a broadening in the allocation of responsibility between physicians and hospitals. Earlier, the supervising physician had been viewed as "captain of the ship," in command of the medical team and personally responsible for all patient care. Since the *Darling* case in the mid-1960s, the hospital as employer and as health care provider has joined the supervising physician in liability with growing frequency.⁵ All of the cases in this group addressed in some way the issue of the allocation of responsibility for the care provided to the patient by the resident.

Most of the cases addressing duty of care turned on the doctrine of vicarious liability by which responsibil-

*As of 1990, Alabama offered 1,061 residency positions; Arizona, 971; Arkansas, 505; California, 7,947; Colorado, 1,009; Connecticut, 1,650; Delaware, 220; District of Columbia, 2,032; Florida, 2,367; Georgia, 1,593; Hawaii, 402; Idaho, 24; Illinois, 5,276; Indiana, 1,078; Iowa, 851; Kansas, 726; Kentucky, 931; Louisiana, 1,599; Maine, 203; Maryland, 2,162; Massachusetts, 3,943; Michigan, 3,833; Minnesota, 2,112; Mississippi, 447; Missouri, 2,216; Nebraska, 489; Nevada, 101; New Hampshire, 238; New Jersey, 2,458; New Mexico, 361; New York, 14,326; North Carolina, 2,335; North Dakota, 115; Ohio, 4,662; Oklahoma, 730; Oregon, 619; Pennsylvania, 5,907; Puerto Rico, 936; Rhode Island, 471; South Carolina, 918; South Dakota, 91; Tennessee, 1,793; Texas, 5,479; Utah, 511; Vermont, 226; Virginia, 1,744; Washington, 1,303; West Virginia, 500; Wisconsin, 1,462; and Wyoming, 42, a total of 92,975 positions.

Table 2
Issues Giving Rise to Litigation

	Duty of Care	Standard of Care	Failure to Supervise	Judicial Procedures	Sovereign Immunity	Breach/Causation	Informed Consent	Other	Total
1950-54	2	1	—	—	—	2	—	—	5
1955-59	6	2	—	—	—	—	—	1	9
1960-64	6	1	—	—	—	1	—	—	8
1965-69	2	3	2	1	—	1	—	1	10
1970-74	4	2	1	—	2	—	—	—	9
1975-79	9	6	2	1	1	3	1	—	23
1980-84	3	10	6	4	4	—	3	—	30
1985-89	8	3	4	12	7	3	2	3	42
Total	40	28	15	18	14	10	6	5	136

ity for the actions of the resident was assigned to the hospital in addition to the primary duty of care assigned to the supervising physician. Generally, liability for injuries suffered by a patient is predicated on a finding that the supervising physician or resident directly failed to exercise the appropriate level of care. To impose vicarious liability upon a hospital, two preconditions must be met. First, there must be a relationship between the resident and the hospital. Most commonly, this exists in the form of an employer-employee or a "borrowed servant" relationship. Second, vicarious liability requires that the resident act within the contemplated scope of the relationship when committing the alleged misdeed. Imposition of vicarious liability upon the hospital does not necessarily exculpate the resident or the supervising physician. It theoretically provides an incentive for those in positions of authority to act with diligence and to coordinate oversight of care delivered by residents and physicians. In practical terms, however, a finding of vicarious liability provides the claimant with other, often more solvent, defendants ("deeper pockets"). Thus, residents defending malpractice claims may often be ancillary parties caught in the legal battle to allocate responsibility between the supervising physician and the hospital. This sorting and distribution of responsibility becomes an even more complex exercise when residency programs utilize different hospitals for training and rely

upon contractual arrangements for complex issues of supervision, staffing, reimbursement, and indemnification.

Standard of care. Twenty-eight (21%) of the cases centered on the standard of care provided to the patient. Of these, 19 cases dealt with defining an overall standard of care for the medical profession and thus reflected the general trend toward creation of national, rather than local, standards of practice by which to evaluate physician performance.⁵ The remaining nine cases focused on the question of whether a separate standard of care applies to residents. During the study period the standard of care for residents underwent evolution from the earlier expectation of that level of performance expected of an "average" resident at a comparable state of training⁶ to the present expectation that the resident perform as a physician, competent by professional standards to practice in his or her specialty area.⁷ The courts appear to be willing to impose on a resident that standard of care expected of a physician-specialist precisely because it is assumed that there will be a "high level of direct supervision by attending physicians."⁵

Failure to supervise. Fifteen (11%) of the cases constituted this category, a group that has apparently arisen since 1965. From a legal perspective, this group of cases also addressed standard of care. However, because all focused specifically on whether the responsible physician or hospital

failed to supervise the resident appropriately, they are grouped separately. These cases are primarily concerned with the *nature* of the duty and responsibility that a supervising physician or hospital has in overseeing the care given to patients by hospital employees, including residents. Often, such cases have focused on the issue of whether the hospital or supervising physician had "reason to know" or "should have known" facts that would have reasonably led to inferring the existence of danger to a patient. Most cases alleged failure by the physician or hospital to exert control over the resident and discussed the scope of supervision to be exercised over the resident. In one case the plaintiff argued that the department chairman failed to develop appropriate programs to educate residents and procedures to monitor residents' performance and practice.⁸ In another case, the plaintiff argued the State Board of Regents failed to ensure appropriate evaluation and monitoring of residents by faculty.⁹ Finally, a failure to exercise appropriate supervision by those responsible for residents often led to a counterclaim against the institution by the various competing interests in the litigation. As examples, depending upon the underlying contractual arrangements, an affiliated hospital sued the training program or the employing hospital, or both, for breach of the duty to supervise, while a resident sued the program for failing in its duty to educate. Such cases occurred

Table 3
Prevailing Party

	Duty of Care	Standard of Care	Failure to Supervise	Judicial Procedures	Sovereign Immunity	Breach/Causation	Informed Consent	Other	Total
Resident	10	15	5	13	7	2	5	3	60
Other	23	12	8	5	4	7	1	2	62
Unclear	7	1	2	—	3	1	—	—	14
Total	40	28	15	18	14	10	6	5	136

when a resident was found to be liable personally or when an insurer challenged a claim for indemnification on a malpractice policy after the hospital or physician was found to be liable.¹⁰

Judicial procedures. Cases in this group required the courts to interpret statutes or rules governing the plaintiff's right to be in court and/or governing compliance with judicial procedures. Of the 18 cases so classified, all were tried in state courts. Twelve (67%) have been decided since 1985, an indication of increasing interest in this area. This growth in procedural challenges has probably been fueled in part by recent state efforts to enact malpractice reform.³ Indeed, recent decisions have focused on procedural issues raised by reform efforts: four cases litigated compliance with statutes of limitations¹¹; three cases dealt with compliance with changes in service and notice requirement at the appropriate stages of developing a claim¹²; and two cases addressed the allowable scope of discovery by the courts.¹³ One case unrelated to tort reform dealt with the issue of whether a resident's statement, given to the hospital insurer and impugning the responsible physician, should be allowed as evidence in court.¹⁴

Immunity from liability. Fourteen (10%) of the cases litigated the issue of immunity from liability. Of these, half were reported since 1985, reflecting emerging interest in this legal issue.

Under certain circumstances immunity provides a jurisdictional bar to the imposition of liability for negligence. Depending on state law, resident physicians may be entitled to sovereign immunity if acting as

agents of the state (e.g., public hospital employee) or charitable immunity if employed by private, not-for-profit organizations. Affiliation agreements between combinations of public and private medical and educational institutions involved in residency training programs pose particularly complex questions of immunity when malpractice is alleged.¹⁵ There is substantial variation in the frequency of reported litigation between states, some of which may be partially attributable to the restrictions with which states apply these doctrines. Over the last five years of this study, cases interpreting changes in the application of the doctrine of sovereign immunity to public hospitals and residents were particular issues in Michigan, Kentucky, and Florida.¹⁶

Breach or causation. Only ten (7%) of the cases involved factual disputes over the alleged negligent act or over whether the act actually caused the injury. These cases, reported sporadically over the study period, litigated whether the verdict or ruling was supported by the evidence presented, the role of circumstantial evidence and the legal doctrine of *res ipsa loquitur*, and whether the injury suffered was directly caused by the tortious conduct of the defendant or failure of the defendant to diagnose.

Informed consent. Treatment performed without a valid consent may be viewed as battery, a separate cause of action at law, but is frequently linked with malpractice litigation. Six cases were identified that addressed informed consent, all since 1975.¹⁷ Of these, two arose from events in Veterans Administration hospitals and were decided by federal courts. The

cases focused on whether the patient knew that the resident and not the supervising physician would be providing care, or alternatively, whether the resident appropriately obtained the patient's consent to a procedure.

Other issues. Five cases could not be specifically categorized.¹⁸ In the earliest, the issue of assumption of risk was decided. In two cases, the court decided issues of contract when insurance carriers disputed a hospital's right to indemnification for a malpractice award against a resident. State limits on recovery for malpractice enacted as a reform effort were challenged in one case. Finally, a claim that a residency program failed to provide an education adequate to ensure competency in practice was litigated.

Prevailing Party

Most of the cases reviewed could be categorized by winning party, in this instance either the party aligned with the resident or the opposing party (Table 3). In several cases a winner could not be determined from the facts of the case, either because the issue was entirely procedural or because a remand was required to retry the facts in dispute. Residents have been on the side of the prevailing party in 60 (44%) of the 136 cases. The outcome was unclear or mixed in 14 (10%) of the cases.

Within the categories of issues litigated, there appeared to be substantial variation in the rates of resident success. The lowest success rates for residents and those aligned with them occurred in cases addressing breach/causation (20%), duty of care where

allocation of responsibility was the primary question (25%), and failure to supervise (33%). Residents were most successful when litigation challenged whether residents had provided adequate informed consent to patients under their care (83%), or the plaintiff's compliance with procedural prerequisites to the suit (72%).

In the remaining categories of cases, outcomes were mixed. When standard of care was the primary issue, the overall outcomes favored residents in 54% of the decisions. However, within the subgroup of cases focused on the standard of care expected of a resident, the outcomes favored residents in six of nine cases (67%). When the focus was on the standard of care expected of the supervising physician, favorable outcomes dropped to nine of 19 cases (45%). Residents prevailed in 50% of the reported decisions in litigation turning on the question of sovereign immunity. Residents were associated with the prevailing party in 60% of the cases classified as other.

Discussion

Litigation involving residents and programs of graduate medical education has increased in frequency over the past 40 years.¹ Malpractice suits constitute the largest group within the body of resident litigation. Our data suggest that malpractice litigation involving resident physicians has increased substantially since 1975, following temporal and geographic patterns similar to those seen nationally.³ Before 1970, malpractice constituted the only area of reported litigation for residents.¹ Although clearly not the only area of exposure to litigation now, malpractice continues to be the key legal issue facing programs of residency training today.

A crude estimate of the volume and frequency of malpractice litigation involving residents may be inferred from information available in the literature. For every 1,000,000 hospitalizations, it is estimated that 46,500 injuries occur.¹⁹ Of those injuries, about 7,905 (17%) are thought to arise from negligence. About one in

ten negligent injuries result in litigation's being filed in court and, of these, only 1% may be included in the legal reporting system.^{20,21} Thus, based on the number of malpractice cases identified in this study through the legal reporting system, we may estimate that 13,700 other suits and 137,000 total injuries related to programs of graduate medical education occurred over the 40-year study period. At least one large study has recently addressed in detail the issue of the frequency of negligence in hospitalization and of claims alleging malpractice.²²

Potential reasons for the growth in the frequency and diversity of malpractice claims against residents and programs of graduate medical education are several. First, as with suits over general academic issues of graduate medical education, there may be a relationship between the risk of malpractice litigation and the expansion in numbers of residents over the period covered by this study.¹ Second, there is limited evidence that claims against physicians occur more frequently earlier in their careers.³ This pattern may extend back even into residency training. Third, the growing complexity of the practice environment in which graduate medical programs operate and the increasing severity of illness of patients cared for by residents may also broaden potential exposure to litigation.⁵ Fourth, the quality of care afforded patients by residents or the quality of supervision provided residents by faculty physicians may have suffered during the period of expansion in graduate medical education. Although no data support this view directly, it should be of concern to conscientious academicians and accorded attention in the development and administration of residency programs. Fifth, the emergence of state tort reform may be increasing the number of test cases in those states where reform legislation exists. There is evidence from our data that a substantial proportion of recent malpractice litigation involving judicial procedure has challenged tort reform efforts.

The outcome of malpractice litigation

involving resident physicians, a 44% success rate generally, appears to be somewhat less favorable than that seen for malpractice cases in general. In one study of three rural states, defendants were reported to have prevailed in 81% of the litigated cases.²³ Over a 20-year period in two urban settings, defendants prevailed less frequently, in 47–73% of cases in San Francisco and 51–75% of cases in Cook County.²⁴ Care must be taken in interpreting the significance of differences in success rates between resident and practicing physicians. Rates for practicing physicians are derived from studies analyzing all malpractice decisions of courts at the trial level. The present study is limited to reported litigation and, because of limitations of the database, incorporates a strong bias towards appellate level decisions.

Recently, in the proceedings of a conference on the regulation of physician training programs, Samuelson² identified three important areas of negligence in graduate medical education: (1) negligence in educational training programs, (2) negligence in supervision, and (3) vicarious liability where the negligent conduct of the trainee is attributed to the supervising physician or employing institution. Results of this survey of the reported case law illustrate the role of the courts in establishing and regulating the liabilities of residents and training programs in two of these three general areas: negligence in supervision and vicarious liability arising from the allocation of responsibility for the duty of care. Together, these two issues constituted 40% of the reported litigation.

Only in the area of negligence in educational training programs, where a program itself was challenged for failing to teach essential information or skills or to require reasonable evidence of competence, did this survey of reported case law find limited evidence of judicial influence. To date, courts in only one state have allowed educational malpractice to be litigated as a separate cause of action at law. That case dealt with secondary schools.²⁵ Only one case identified by

this survey claimed directly that a residency program had committed educational malpractice in failing to teach and to supervise. That claim, brought against a program by a resident who was himself being sued for malpractice, was denied.²⁶ However, in two cases, liability for the negligent actions of residents was attributed to programs that failed in their duty to supervise residents properly and not to supervising physicians.²⁷ In neither did the court label this failure educational malpractice; but in both, a breach of the duty of the program to teach and to supervise residents was found to be the direct cause of an injury. In a third case, a department chairman was at fault for not establishing appropriate standards for supervision and evaluation of residents.⁸ Claims brought as a failure to supervise by a program or faculty member may have the same net effect as a claim for educational malpractice. However, this blurring of the distinction between negligence in supervision of trainees and educational malpractice may be offset by the fact that a claim for negligent supervision is limited to the duration of a resident's training program, whereas a claim for educational malpractice would extend without limit.

Malpractice litigation raises issues for the administration of residency training programs. The significance of a program's failure to provide adequate supervision or education has been discussed previously in several cases. The level of administration at which responsibility for supervision should be assigned has also been addressed by the courts. One case alleged the malpractice to be attributable to a failure by the State Board of Regents to limit the scope of practice and responsibilities assigned residents.⁹ In a second, a department chairman was found to have failed in his duties to provide adequate supervision and to develop adequate procedural guidelines for the residents in the program, thus becoming the cause, in fact and proximately, of the resultant injury to the patient.⁸ Most commonly, however, cases focus on the immediate supervision provided

by the physicians in charge, the hospital as the residents' employer, and the appropriate allocation of authority and responsibility for actions taken by the resident between these two primary parties. The finding that almost 40% of the cases identified by this study decided questions of allocating responsibility for the duty of care and failure to supervise emphasizes the importance of setting policies that clearly delineate for faculty levels of supervision and responsibilities for supervision. The previously cited potential for legal difficulties arising from the team approach to patient care is thus confirmed by the case law in this review.⁶

Several cases identified prototypical problems of programs using two or more hospitals as training sites for their residents.²⁸ These problems often become particularly difficult because of cooperative arrangements between affiliated hospitals and programs. In suits involving public and private entities, the nongovernmental affiliate may become the "deep pocket" for malpractice claims that exceed the statutory limits of liability protecting public hospitals and programs, or when the private institution seeks protection under the umbrella of sovereign immunity. These disputes may be initiated by the insurance carrier after an accident has occurred, liability has been assigned, and indemnification has been sought by the program or hospital from the insurer. More typically, these suits seek simply to widen access to a "deep pocket" by establishing dual responsibility for malpractice by a resident between the program and the affiliated hospital through a close reading of affiliation agreements. Cooperative arrangements between institutions involved in residency training require ongoing review and monitoring to ensure compliance with the provisions of the affiliation agreement and prompt identification, reporting, and handling of incidents that do occur.

Over the study period the courts have substantially revised their interpretation of the law in the area of standards of care. The general trend of requiring all physicians to conform

to national norms of practice is reflected in the results reported for supervising physicians. However, the application of that standard specifically to residents does not appear to have had adverse results or decreased their success in defending such cases. In part, however, this may be due to the courts' aggressiveness in ensuring that supervising physicians exercise direct control over the care delivered to patients by residents.

Similarly, the courts have generally sustained residents, who, as members of a team, obtained consent to perform a procedure upon patients. Relatively few cases focused on this issue were reported despite the attention paid to this problem in the literature.²⁹ In the only case to find inadequate consent, the supervising physician, not the resident, was found to be liable.³⁰

In summary, this research on litigation affecting residency training programs confirms and expands the literature describing issues in medical malpractice in several ways. First, the frequency of malpractice litigation involving residents would appear to conform to general malpractice trends nationally. Second, a substantial proportion of the litigation focused on issues related to allocation of responsibility between hospital and responsible faculty for substandard care provided by a resident no matter what the cause. Finally, a significant group of cases identified reflects the complexity of the contemporary legal environment in which training programs operate. These issues include the complex institutional arrangements between participating organizations as well as state law requirements protecting public programs and limiting access to the courts. The growing exposure of programs of graduate medical education to malpractice litigation requires proactive communication between physicians, administrators, and legal counsel, as well as continued efforts at the state level to effect tort reform.

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